Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JILL R PAYNE, MA, LPC
6660 AIRLINE DRIVE
HOUSTON TEXAS 77076

Respondent Name
TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-08-0450-02 formerly M4-08-0450-01

MFDR Date Received
September 17, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "Our facility had preauthorization for these services."

Amount in Dispute: $5,700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant was notified in January that radiculopathy was disputed. The provider was notified in the preauthorization letter that the dispute existed. Medical necessity for treatment is the only thing the preauthorization is based on, not whether the treatment is compensable. Compensability, according to the rule, is not to be considered when determining if treatment is medically necessary for the condition being treated."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2007 to June 1, 2007	Chronic Pain Management	$5,700.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 4, 2007

- W12 – Extent of injury. Not finally adjudicated. Thoracic/lumbosacral neuritis/radiculitis has been denied/disputed

Explanation of benefits dated June 18, 2007

- W12 – Extent of injury. Not finally adjudicated. Referenced treatment has been denied/disputed.

Explanation of benefits dated May 30, 2007

- W1 – Workers Compensation State Fee Schedule Adjustment. Reimbursement for 6 hours. Per documentation only 6 hours is noted & supported.

Issues

1. Did the requestor bill for treatment of a compensable body area?
2. Is the requestor entitled to reimbursement?

Findings

1. A Decision and Order signed on April 18, 2008 indicates that the claimant's compensable injury of March 4, 2004 does not extent to or include degenerative changes of the L4-5 disc, a herniation of the L5-S1 disc, or facet arthropathy at the L3-4 or L4-5 spinal levels.
2. Review of the submitted documentation finds that services rendered were for the treatment of the non-compensable body area. As a result, the healthcare provider is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.